



Federal Issues

Legislative

Senate Moves to End Shutdown

On Sunday evening, eight Senate Democrats joined all their Republican colleagues to end debate and advance legislation that would reopen the federal government.

The Deal: The bipartisan agreement includes a proposed CR-minibus package that extends government funding through January 30 along with three full-year appropriation bills (Agriculture, Military Construction-Veterans Affairs, and Legislative Branch).

In addition to the funding, the deal includes rehiring federal workers dismissed during the shutdown, providing backpay for furloughed employees, and extending Medicare telehealth flexibilities.

As part of the deal, Majority Leader John Thune (R-ND) has committed to bringing an ACA bill to the Senate floor by the second week of December. However, whatever legislation is brought to the floor will have an uphill battle obtaining the necessary 60 votes to pass.

Text and a section-by-section of the CR-minibus are available [here](#).

In this Issue:

Federal Issues

Legislative

- Senate Moves to End Shutdown
- Senate Subcommittee Holds Hearing on Affordable Care Act

Regulatory

- White House Announces Agreement on Prices for Weight-Loss Drugs
- CMMI Announces New Voluntary Medicaid GENEROUS Model
- CMS Finalizes 2026 Medicare Physician Fee Schedule
- CMS Announces All 50 States Applied for Rural Health Transformation Program
- IRS Releases Updated PCORI Fee
- CMS Issues Informational Bulletin on Reducing Duplicate Medicaid , CHIP Enrollment

Next Steps: The House is expected to vote on this package as soon as Wednesday of this week. Public opposition has already been raised by many Democratic House members. The package can advance without their support, however, if Speaker Mike Johnson can maintain unity within his conference.



Senate Subcommittee Holds Hearing on Affordable Care Act

The Senate Permanent Subcommittee on Investigations (PSI) held a [hearing](#) titled “Assessing the Damage Done by Obamacare.” A video of the hearing and witness testimony are available [here](#).

Witnesses Included:

- **Joel White**, Council for Affordable Health Coverage
- **Tarren Bragdon**, Foundation for Government Accountability
- **Brian Blase, PhD**, Paragon Health Institute
- **Shana Verstegen**, Small Business Employee and ACA Marketplace Enrollee

Top Issues: Key topics addressed by Senators and witnesses included the impact of enhanced premium tax credits on premiums, allegations of so-called “phantom” enrollees, and recent changes to Medicaid made through the *One Big Beautiful Big Act*.

- Health policy experts continue to [rebut](#) claims of “phantom enrollees” and data show the [vast majority](#) of tax credits go to lower- and middle-income households earning under \$200,000. An [analysis](#) by coalition partner Keep Americans Covered responding to claims of “fraud” was also entered into the record from Ranking Member Richard Blumenthal (D-CT).

AHIP Statement: “The individual market is a vital source of coverage for 24 million Americans who are not eligible for government programs or do not have an offer of coverage through their employer. If Congress fails to extend the health care tax credits, millions of middle-income Americans – including working families, sole proprietors, employees of small businesses, gig workers, residents of rural communities and others – face the largest ever increase in health care costs in 2026, causing many to lose coverage altogether. Congress should act as quickly as possible to protect Americans from this cost-of-living crisis.”

Go Deeper: [By the Numbers: The Importance of the Health Care Tax Credits](#).

Federal Issues

Regulatory

White House Announces Agreement on Prices for Weight-Loss Drugs

The President announced deals on GLP-1 pricing with drugmakers Eli Lilly and Novo Nordisk. According to the White House, these most-favored nation (MFN) pricing agreements “will enable Medicare and Medicaid to cover obesity drugs for adults.” Notably, Novo Nordisk’s Ozempic and related products will be subject to Medicare-negotiated prices in 2027, a price ceiling widely expected to cause Lilly’s competing products to sharply reduce prices in the Medicare program.

Why this matters: While the full operational details of the agreement have yet to be released, the intent as announced is to lower prices for GLP-1s used to treat both diabetes and obesity in the Medicare and Medicaid markets for 2026 – presumably under a mandatory demonstration in Medicare and a state-level opt-in demonstration in Medicaid. According to the White House, the prices achieved under these agreements “will enable Medicare to cover Wegovy and Zepbound for patients with obesity and related comorbidities for the first time.”

Under the MFN agreements, the Medicare prices of Ozempic, Wegovy, Mounjaro, and Zepbound will be \$245 a month, with Medicare beneficiary copays of \$50 a month. State Medicaid programs will have access to the same MFN pricing. In addition, these lower prices will also be available for cash purchases through [TrumpRx.com](https://trump-rx.com). The drugmakers have made no commitments to lower prices for these products in the commercial market.

AHIP Statement: “We look forward to reviewing the details of today’s announcement and agree with policymakers on both sides of the aisle on the importance of addressing obesity and other chronic illnesses. Health plans are doing everything in their power to shield consumers from the full impact of the exorbitant prices drugmakers set and which they alone can lower. As drugmakers relentlessly lobby for a blank check to keep overcharging Americans, continued bipartisan action to lower drug prices is critical – including commonsense reforms to stop drugmakers’ abuse of the patent system, restore competition, and move toward pricing based on clinical value and not on the lavish tax-deductible marketing campaigns brand drugmakers use to drive up consumer demand for high-priced drugs and raise costs for everyone.”

Read more in the White House fact sheet, available [here](#).

CMMI Announces New Voluntary Medicaid GENEROUS Model

What’s happening: The Center for Medicare and Medicaid Innovation Center (CMMI) announced the [GENErating cost Reductions for U.S. Medicaid \(GENEROUS\) Model](#). This is a voluntary five-year model whereby drug manufacturers will provide supplemental rebates to participating states for certain covered outpatient drugs (CODs) to align with most favored nation (MFN) prices.

Why this matters: This model is meant to facilitate access to MFN pricing in Medicaid and follows the announcement of several MFN agreements by Pfizer, AstraZeneca, and EMD Serono, and includes [yesterday’s MFN announcement](#) with Eli Lilly and Novo Nordisk.

- The GENEROUS Model should reduce Medicaid expenditures for drugs included in the model through negotiation of supplemental rebates and ideally improve access and health outcomes.

- **This model will impact health plans with Medicaid managed care contracts in participating states where the Plan manages the pharmacy benefit.**

The details: MFN refers to a policy by which American drug prices align with the lowest price paid in other developed countries as outlined in a May [executive order](#).

- CMS indicates that manufacturers that have recently entered into similar agreements with the Administration, including AstraZeneca, Pfizer, and EMD Serono, will participate in the GENEROUS Model after certain terms are finalized.

Timing: The GENEROUS Model will have an initial performance period of Jan. 1, 2026 – Dec. 31, 2030. In exchange for offering lower drug prices, manufacturers will receive standardized coverage criteria across all participating states. Additional information can be found on the GENEROUS Model [website](#)

Model overview:

- **Manufacturer Participation:** Participating manufacturers must have an active rebate agreement through the Medicaid Drug Rebate Program. The [request for applications](#) for interested manufacturers is now available and the submission period closes Mar. 31, 2026.
- **State Medicaid Participation:** Interested state Medicaid agencies must submit letters of intent and will be able to review pricing information prior to formally joining. This will be followed by a formal request for application for states to be able to enroll on a rolling basis by Aug. 31, 2026.
- **Eligible Drugs:** Single source drugs or innovator multiple source drugs of a participating manufacturer are eligible under this model. CODs already included in the Cell and Gene Therapy model are excluded.
- **MFN Price and Rebate Calculation:** Manufacturers must report the international net unit price for each COD to CMS and supplemental rebates would be invoiced to manufacturers by states on a quarterly basis. The benchmark used to calculate the MFN price for each COD will be based on the average net international price for the drug at which it is sold in the G-7 countries, Denmark, and Switzerland (excluding the US).
- **Coverage Terms:** CMS will negotiate coverage terms for each COD, with state input. States will have additional flexibility to determine which CODs they would like to access MFN pricing for with each participating manufacturer.
- **Implications for Medicaid Best Price and 340B:** Supplemental rebates provided to states by participating manufacturers does not change Medicaid Best Price and therefore does not affect ceiling prices offered under the 340B Drug Discount Program

CMS Finalizes 2026 Medicare Physician Fee Schedule

On October 31, CMS [finalized](#) the 2026 Medicare Physician Fee Schedule, including a downward 2.5% efficiency adjustment to certain procedures and a 50% reduction in indirect practice expense (IPE) payments for facility-based providers.

Key Changes: CMS is exempting time-based codes, telehealth services, and new 2026 codes from the efficiency adjustment, while shifting IPE payments to favor office-based doctors. CMS noted it is moving away from AMA survey data in valuing services, citing outdated assumptions and low response rates, and is seeking better data to guide future rulemaking.

Next Steps: The rule is set to take effect on January 1, 2026.

Go Deeper: Read the CMS fact sheet [here](#).

CMS Announces All 50 States Applied for Rural Health Transformation Program

CMS announced that all 50 states had submitted applications for the \$50 billion Rural Health Transformation Program. CMS will now review all applications to ensure completeness with requirements outlined in the Notice of Funding Opportunity. States that have met these requirements in their application will receive baseline funding, representing half of all available program funds, distributed equally among states. CMS will then conduct a “rigorous, data-driven merit review” of applications that met these baseline criteria to determine how to distribute the remaining 50% of available program funds among states. CMS will announce approved awardees by Dec.31, 2025 with funding to be distributed across five years beginning in federal fiscal year 2026. [Read More](#)

IRS Releases Updated PCORI Fee

On Nov. 3, 2025, the Internal Revenue Service (IRS) released [Internal Revenue Bulletin 2025-45](#), which includes Notice 2025-61 that sets the fee imposed on issuers of health insurance policies or plan sponsors of self-insured plans to fund the Patient-Centered Outcomes Research Institute (PCORI).

The updated fee amount is \$3.84 per average covered life. This is an increase of \$0.37 over the previous PCORI fee. The fee is due by July 31 annually based on the average number of lives covered under the policy or plan during the policy plan year.

- [Fierce Healthcare Article](#)
-

CMS Issues Informational Bulletin on Reducing Duplicate Medicaid, CHIP Enrollment

CMS released a Center for Medicaid and Children’s Health Insurance Program (CHIP) Services (CMCS) Informational Bulletin (CIB) reminding states of their responsibility to identify individuals who are concurrently enrolled in Medicaid or CHIP in more than one state and redetermine eligibility for those individuals. In the bulletin, CMS notes it will soon provide each state with a file listing individuals concurrently enrolled in Medicaid or CHIP in their state and at least one other state between June and August 2025, and outlines steps that the state must take to redetermine whether these individuals still meet Medicaid eligibility requirements for the state.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: <http://legis.delaware.gov/>.

New York Legislation: <https://nyassembly.gov/leg/>

Pennsylvania Legislation: www.legis.state.pa.us.

West Virginia Legislation: <http://www.legis.state.wv.us/>

For copies of congressional bills, access the Thomas website – <http://thomas.loc.gov/>.

The content of this email is confidential and intended for the recipient specified only. It is strictly forbidden to share any part of this message with any third party, without a written consent of the sender. If you received this message by mistake, please reply to this message and follow with its deletion, so that we can ensure such a mistake does not occur in the future.